

DEMOGRAPHICS AND HIPAA NOTICE

Date: _____

Last Name _____ First _____ Middle _____

Preferred Name _____ Marital Status _____

Date of Birth _____ Sex Male Female SSN# _____

Race: White Pacific Islander
 Black American Indian
 Asian Other

Ethnicity: Hispanic/Latino
 Not Hispanic/Latino

Preferred Language: English
 Spanish
 Other

Mailing Address _____ City _____

State _____ Zip Code _____ Email _____

Home Phone (____) _____ Work (____) _____

Cell (____) _____ Primary Number Home Work Cell

Preferred contact method for Appointments/Results? Voice Call Text (could result in charges from your carrier)

Employer _____ Occupation _____

Employer Address _____

Preferred Pharmacy _____ Family Doctor _____

Referring Doctor _____

Insured Name _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Phone (____) _____

Emergency Contact Relationship _____

FOR MINORS AND STUDENTS

Father's Name _____ Date of Birth _____

If insured policy holder

Mailing Address (if different from above) _____ Phone (____) _____

CITY _____ STATE _____ ZIP _____ SSN# _____

Mother's Name _____ Date of Birth _____

If insured policy holder

Mailing Address (if different from above) _____ Phone (____) _____

CITY _____ STATE _____ ZIP _____ SSN# _____

TURN OVER TO CONTINUE ON BACK